STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS HEALTH AND REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

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F 000	INITIAL COMMENTS An Abbreviated Survey was initiated on 10/27/15 and concluded on 10/29/15 to investigate complaint KY 23982. The Division of Health Care unsubstantiated the allegation with unrelated deficiencies cited.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to follow the care plan for one (1) of five (5) sampled residents, (Resident #3). The staff failed to obtain a Podiatrist Consult for Resident #3 as directed by the care plan intervention to provide foot care. The findings include: Interview with the Minimum Data Set (MDS) Coordinator, on 10/29/15 at 11:33 AM, revealed she followed the RAI and that was the policy she followed. Review of the MDS 3.0 Section 4, 4.7, page 4-11, #12, revealed the Interdisciplinary Team identified specific, individualized steps or approaches that would be taken to help the resident achieve his or her goals. These approaches serve as instructions for resident care and provide for the continuity of care by all staff. Precise and concise instructions help staff	F 282		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/20/2015

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F 282	Continued From page 1	F 282		

understand and implement interventions.

Review of Resident #3's clinical record revealed the facility admitted the resident on 06/10/15 with diagnoses of Paral Polio, Muscle Weakness, Obesity, Edema and Lack of Coordination. Review of Resident #3's Quarterly Minimum Data Set (MDS Assessment, dated 09/15/15, revealed the facility assessed Resident #3 using a Brief Interview for Mental Status (BIMS) and scored a fifteen (15) which meant the Resident was interviewable.

Review of Resident #3's Comprehensive Care Plan, dated with a problem onset of 06/30/15, revealed Resident #3 had bilateral foot drop, contractures and edema. The goal stated Resident #3 would not have adverse effects or skin breakdown due to the bilateral foot drop and contractures. The intervention was for staff to provide foot care.

Interview with Resident #3, on 10/27/15 at 2:05 PM, revealed his/her feet were infected and the Nurse Practitioner stated she would have the Podiatrist come to see him/her about two (2) months ago and it had not occurred as of yet.

Review of Resident #3's Physician Orders, dated 09/08/15 (51 days ago), revealed an order for a Podiatry Consult as soon as possible (ASAP), to right great toe for Paronychia (an infection that develops along the edge of the fingernail or toenail).

Observation of Resident #3's feet, on 10/29/15 at 10:35 AM, revealed Resident #3's right big toe was observed to have dark red and yellow scab in the bed of the toe nail. The right third (3rd) digit

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F 282	Continued From page 2 was observed to be yellow in color. The left big toe was observed to have a black scab on the bed of the toe nail. Both feet and shins were observed to be swollen. Interview with Licensed Practical Nurse (LPN) #1, on 10/29/15 at 10:35 AM, revealed the nursing staff initiated the care plan when a resident was admitted and could update the care plan as new orders were ordered. LPN #1 stated the MDS Coordinator and the Assistant Director of Nursing (ADON) were responsible for the comprehensive care plan. LPN #1 stated staff was expected to follow the care plan. Interview with the MDS Coordinator, on 10/29/15 at 11:33 AM, revealed she became involved with the care plan when she completed the admission assessment of the resident. The MDS Coordinator stated staff were expected to follow the care plans because it was the plan of care for the residents. The Podiatrist order was a nursing measure for providing the foot care as stated on the care plan. Interview with the ADON, on 10/29/15 at 10:52 AM, revealed staff were expected to follow the care plan. The ADON stated the Podiatrist order was a nursing measure for providing the foot care as directed by the care plan. Interview with the Director of Nursing (DON), on 10/29/15 at 11:45 AM, revealed the plan of care stated the staff was to provide foot care and a part of that foot care would be the orders to provide foot care. The DON stated the staff were expected to follow the care plans as directed.	F 282		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=D	Continued From page 3 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to follow the physician orders for one (1) of five (5) sampled residents, (Resident #3). The staff failed to follow the order for a Podiatrist Consult ordered on 09/08/15, 51 days ago, to be provided as soon as possible (ASAP) . The findings include: The facility did not provide a policy on following physician orders. Review of Resident #3's clinical record revealed the facility admitted the resident on 06/10/15 with diagnoses of Paral Polio, Muscle Weakness, Obesity, Edema and Lack of Coordination. Review of Resident #3's Quarterly Minimum Data Set (MDS) Assessment, dated 09/15/15, revealed the facility assessed Resident #3 using a Brief Interview for Mental Status (BIMS) and scored a fifteen (15) which meant the resident was interviewable.	F 309		

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F 309	Continued From page 4	F 309		

Interview with Resident #3, on 10/27/15 at 2:05 PM, revealed he/she did not have pressure though both of his/her feet were infected. Resident #3 stated about two (2) months ago the Nurse Practitioner said she would have the Podiatrist come to see him/her; however, he/she had not seen the podiatrist as of yet.

Review of Resident #3's Physician Orders, dated 09/08/15 (51 days ago), revealed an order for Podiatry Consult ASAP to right great toe for Paronychia (An infection that develops along the edge of the fingernail or toenail).

Interview with Resident #3 and observation of Resident #3's feet, on 10/29/15 at 10:35 AM, revealed Resident #3's right big toe had a dark red and yellow scab in the bed of the toe nail. The right third (3rd) digit was yellow in color. The left big toe had a black scab on the bed of the toe nail. Both feet and shins were swollen. Resident #3 stated he/she had a family member to cut his/her toenails because no one from the facility would cut his/her nails.

Interview with Licensed Practical Nurse (LPN) #1, on 10/29/15 at 10:30 AM, revealed Resident #3's feet looked like it had dry blood and an in grown toe nail. LPN #1 stated it did not look infected. She stated when the nurses obtained orders for a Podiatrist Consult, the nurses would call Medical Records to set up the appointment. LPN #1 stated that ASAP meant as soon as possible because something was going on that needed to be seen.

Interview with Medical Records, on 10/28/15 at 2:32 PM, revealed she did not receive the order for Resident #3 to see the Podiatrist on 09/08/15.

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The Medical Records stated if she was not in the building the staff knew to call her and leave a message. She stated she was responsible to make the Podiatrist appointments.

Interview with the Assistant Director of Nursing (ADON) on the second (2nd) floor, on 10/29/15 at 10:52 AM, revealed she was not aware Medical Records did not obtain the order. The ADON stated Resident #3 voiced that a family member came in to clip his/her toenails and to cut out the ingrown nail. Resident #3 stated a family member applied antibiotic ointment on the nail as well. The ADON stated she verbalized the importance of not having family come in to cut his/her nails. The ADON stated Resident #3's legs had been swollen, but they were now more swollen in appearance.

Interview with Resident #3's Advanced Practical Registered Nurse (APRN), on 10/28/15 at 2:40 PM, revealed Paronychia was defined as all the skin around the nail develops a puss pocket and needs to be opened and drained. The APRN stated the facility did not carry numbing medicine or she would have relieved the pressure herself. The APRN stated she wrote the order ASAP because she meant for the facility to make the appointment as soon as possible. She stated she could have sent Resident #3 to the Emergency Room, but that would have been a waste of a bill, when the Podiatrist could do the procedure. The APRN stated she was not aware the facility did not follow through with the order. She stated nursing staff did not call her to inform her the order should be discontinued or that a family member had come to clean out the foot.

Interview with the Director of Nursing (DON), on

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F 309	Continued From page 6 10/29/15 at 11:45 AM, revealed she was not aware Medical Records was not made aware of the order for the Podiatrist. The Nursing staff should have made sure the orders were followed up on as prescribed. The DON stated there should have been a discontinue order if the family had removed the infection.	F 309		